COUNTY OF LOS ANGELES
Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL
Incident Reporting Form

SUBMIT INCIDENT REPORTING FORM TO:
Website: http://publichealth.lacounty.gov/sapc/
Fax: (XXX) XXX-XXXX

PATIENT INFORMATION			
1. Name (Last, First, and Middle):	2. Date of Birth (MM/DD/YY):		3. Medi-Cal Number:
4. Address:			5. Phone Number: Okay to Leave a Message? ☐ Yes ☐ No
6. Gender:	7. Preferred Language	8. Race/Ethnicity (Optional)	
9. A brief description of the patient's current condition including diagnosis(es), level of care, and any other pertinent information.			

PROVIDER AGENCY WHERE INCIDENT OCCURRED		
10. Provider Agency Name:	11. Contact Person:	12. Phone Number:
13. Address:		14.Contact Person/Agency Email Address:
15. Date of Incident (MM/DD/YY) :	16. Time of Incident:	

17. Clinical Incident Type: (Check all that apply)

☐ Death – Other Than Suspected/ Known Medical Cause
☐ Death – Suspected/Known Medical Cause
☐ Death – Suspected Suicide
☐ Suicide Attempt Requiring Emergency Treatment (EMT)
☐ Client Injured Self (Not Suicide Attempt)/ Or Was Injured by Another Client
☐ Client Injured another Client
☐ Client Injured Staff, Visitor, or Others
☐ Medication Error/Medication Event
☐ Alleged Client Abused By Staff
☐ Possibility or Threat of Legal Action
☐ Other _____

Client Name: _____Medi-Cal ID:_____

Treatment Agency:_____

DESCRIPTION OF THE INCIDENT

18. Please describe the nature of the incident. Include any important information about the incident, such as the date, person(s) involved, witnesses, etc. Attach additional sheets, if needed.

19. List any pre-disposing factor(s) or root cause(s) relevant to this incident:

RESPONSE AND FOLLOW UP ACTION

20. Please describe the staff response to the incident. Include description of intervention(s) applied when dealing with the incident. Attach additional sheets, if needed.

21. List any case reviews, trainings, changes to policies and procedures, or follow up by the Risk Management Committee that were performed or instituted in order to prevent similar events in the future.

22. Reporting Staff Name:	23. Manager Name:	24. Manager Signature:	25. Date:

INTERNAL SAPC USE ONLY

☐ Reportable Incident (Logged) ☐ Adverse Event (Logged) ☐ Issue of Concern (Logged) ☐ No Further Action Needed

Comments:

Reviewed by: _____ Signature: _____ Date: _____

Client Name: _____Medi-Cal ID:_____

Treatment Agency:_____

CLINICAL INCIDENT FORM INSTRUCTIONS

PATIENT INFORMATION

1. Enter the patient's name in the order of last name, first name, and middle name.
2. Enter the patient's date of birth.
3. Enter the patient's Medi-Cal number. If the number is not known, leave the space blank.
4. Enter the patient's address.
5. Enter the patient's phone number. Check box to indicate if it is okay to leave a message at this phone number.
6. Enter the patient's gender.
7. Enter the patient's preferred language.
8. Enter the patient's race/ethnicity (optional).
9. Enter a brief description of the patient's current condition including diagnosis(es), level of care, and any other pertinent information.

PROVIDER AGENCY WHERE INCIDENT OCCURRED

10. Enter the provider agency's name.
11. Enter the name of the provider agency's contact person.
12. Enter the contact person's phone number.
13. Enter the provider agency's address.
14. Enter the provider agency's or the contact person's email address.
15. Enter the date of incident.
16. Enter the time of incident.
17. Clinical incident type: (check all that apply).
18. Please describe the nature of the incident. Include any important information about the incident, such as the date, person(s) involved, names of the witnesses, etc. Attach additional sheets, if needed.
19. List any pre-disposing factor(s) or root cause(s) relevant to this incident.

INCIDENT RESPONSE AND FOLLOW UP ACTION

20. Please describe the staff response to the incident. Include description of intervention(s) applied to when dealing with the incident. Attach additional sheets, if needed.
21. List any case reviews, trainings, changes to policies and procedures, or follow up by the Risk Management Committee that were performed or instituted in order to prevent similar events in the future.
22. Enter the name of the reporting staff.
23. Enter the name of the manager.
24. Enter the signature of manager.
25. Enter the date the manager signed the report.

INTERNAL SAPC USE ONLY

This section reserved for internal SAPC use only.

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